

**VERMONT DEPARTMENT OF HEALTH'S  
ADVANCE DIRECTIVES FOR HEALTH CARE RULES**

**I     Purpose**

These rules are adopted to effectuate the intent of Chapter 231 of Title 18, Vermont Statutes Annotated (V.S.A.), Advance Directives for Health Care and Disposition of Remains. Persons with questions about the rules are encouraged to call the Department at (802) 863-7200 or 1-800-464-4343.

The State of Vermont recognizes the fundamental right of an adult to determine the extent of health care the individual will receive, including treatment provided during periods of incapacity and at the end of life. 18 V.S.A. Chapter 231 enables adults to retain control over their own health care through the use of advance directives, including appointment of an agent and directions regarding health care and disposition of remains.

Vermont's law pertaining to advance directives for health care and disposition of remains may be found at 18 V.S.A. Chapter 231 (Sections 9700-9720):

<http://www.leg.state.vt.us/statutes/sections.cfm?Title=18&Chapter=231>

**II    Definitions**

A. The definitions of terms contained in these rules are the same as those contained in 18 V.S.A. § 9701. If any of such legislative definitions are amended, the amended definitions shall be the definitions of the terms contained in these rules.

B. Additional definitions for purposes of these rules:

1. "Advance Directive Locator" shall mean a document submitted to VADR (defined below) describing the physical location(s) of an advance directive.
2. "COLST" shall mean a Clinician Order for Life Sustaining Treatment.
3. "Department" shall mean the Department of Health.
4. "EMS personnel" shall mean emergency medical personnel.
5. "File" shall be information and documents submitted to the Vermont Advance Directive Registry (VADR) and accessible to authorized persons and entities, including the registration information, advance directive, Advance Directive Locator, and any amendment, suspension or revocation, as well as COLST and Do Not Resuscitate (DNR) Orders should the legislature authorize the submission of those documents to VADR.
6. "Health care provider" shall mean a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in Vermont to an individual during that

individual's medical care, treatment, or confinement. The term shall include emergency medical personnel.

7. "Provider" shall mean a health care provider, health care facility, residential care facility, funeral director, crematory operator, cemetery official, organ procurement organization, probate court official, and the employees thereof.
8. "Registrant" shall be a principal who has submitted an advance directive or an Advance Directive Locator to VADR.
9. "Registration Agreement" shall mean consent by the principal for the principal's advance directive personal and emergency contact information to be scanned and stored in VADR for retrieval by providers in accordance with Vermont law.
10. "Staff member" shall mean those persons acting on behalf of a health care facility or residential care facility, whether or not paid by the facility.
11. "VADR" shall mean the Vermont Advance Directive Registry located at:

Vermont Advance Directive Registry  
c/o USLWR  
523 Westfield Ave., P.O. Box 2789  
Westfield, NJ 07091-2789  
Phone: 1-800-548-9455  
Fax: 1-908-654-1919

The Department of Health is legally responsible for VADR and its maintenance. Persons with questions about VADR are encouraged to call the Department at (802) 863-7200 or 1-800-464-4343.

### III Attachments

- |              |   |
|--------------|---|
| Attachment A | Comprehensive advance directive with explanation of choices and responsibilities of a principal executing an advance directive. This is an optional form. Links to other optional forms will be provided at the Department's website. |
| Attachment B | Do Not Resuscitate (DNR) Order and Clinician Order for Life Sustaining Treatment (COLST)<br>The DNR/COLST form is designed to be used as one form.  |
| Attachment C | VADR Registration Agreement   |
| Attachment D | VADR Advance Directive Locator  |
| Attachment E | VADR Authorization to Change  |
| Attachment F | VADR Provider Notification  |
| Attachment G | VADR Agent/Guardian Notification  |

#### **IV. Advance Directives**

1. Agents, guardians, health care providers, health care facilities, residential care facilities, staff members, funeral directors, crematory operators, cemetery officials and persons appointed to arrange for the disposition of the principal's remains, when making decisions concerning a principal without capacity or for a deceased principal, shall follow the instructions in the advance directive regardless of the form of the advance directive.
2. The Department shall maintain a website which contains links to a variety of advance directive forms particularly suited to persons with a variety of interests or concerns, including a comprehensive advance directive covering the alternatives provided for under 18 V.S.A. Chapter 231.
3. A principal may execute any or all parts of any advance directive.
4. Attachment A constitutes a comprehensive advance directive with an explanation of choices and responsibilities of a principal executing an advance directive. This is an optional advance directive. Links to other optional forms will be provided at the Department's website.

#### **V. Clinician Orders for Life Sustaining Treatment (COLST)**

1. At any time a patient may need life sustaining treatment, the patient's clinician shall determine, to the extent possible and in accordance with the relevant sections of 18 V.S.A. Chapter 231, the wishes of the patient regarding life sustaining treatment, and shall record those wishes in the patient's medical chart.
2. A Clinician Order for Life Sustaining Treatment (COLST) is a form which is available for health care providers and health care facilities to summarize orders regarding life sustaining treatment so that the orders are readily accessible to staff who will implement them.
3. Each health care facility shall consider whether to adopt a COLST for use by the facility's medical staff. Attachment B is a combination DNR Order form and COLST form. This form is designed to be used as one form.
4. Any order for life sustaining treatment must be based on properly documented consent.

#### **VI. Do Not Resuscitate (DNR) Protocols, Orders and Identifications**

##### **A. Do Not Resuscitate (DNR) Protocol**

1. Each health care facility and residential care facility must adopt a DNR protocol ensuring that DNR orders are issued, revoked, and handled according to the same standards and process for each patient at the facility.

2. A copy of the facility's DNR protocol shall be made available to anyone upon request.

## **B. Do Not Resuscitate (DNR) Order**

1. A Do Not Resuscitate (DNR) Order must:
  - a. certify that the clinician has consulted, or made an effort to consult with, the patient and the patient's agent or guardian, if there is one;
  - b. identify who has provided informed consent for the DNR Order, if the order is based on informed consent;
  - c. certify that resuscitation would not prevent the imminent death of the patient should the patient experience cardiopulmonary arrest, if the order is not based on informed consent;
  - d. certify that the requirements of the health care facility's DNR protocol have been met, if the patient is in a health care facility; and
  - e. be signed by the patient's clinician and also signed and certified by a second clinician if the order is not based on informed consent.
2. Attachment B is a combination DNR Order and COLST form. This form is designed to be used as one form.
3. If a DNR order is based on consent (i.e., the DNR Order is not based on medical futility and is certified by two clinicians), all health care providers, including emergency medical personnel, and all staff members shall honor the DNR Order unless, the health care provider or staff member:
  - a. believes the patient is not the person identified in the DNR Order; or
  - b. consults the agent or guardian where possible and appropriate, and believes in good faith that the patient wishes to have the DNR Order revoked; or the
  - c. principal revokes or indicates he/she wants different treatment to be resuscitated
4. Whenever a DNR Order is not honored for one of the reasons contained in subparagraph 3, the health care provider or staff member shall document the basis for that decision in the patient's medical record.

## **C. Do Not Resuscitate (DNR) Identification (ID)**

1. Upon issuing a DNR Order, a clinician may authorize the issuance of one or more types of DNR identification to the patient or the patient's caregivers. The DNR ID shall identify the principal as an individual who has a DNR

order. The DNR identification shall be appropriate to the circumstances, and may consist of a bracelet or other jewelry, or a wallet card.

2. Contact information of organizations which provide DNR ID may be obtained from the Department of Health.
3. A patient may suspend or revoke a DNR Identification which is not based on medical futility at any time by the patient's signing a statement, informing the clinician, removing, burning, tearing, obliterating or acting in any way which evidences a specific intent to suspend or revoke the DNR Identification.

#### **D. Emergency Medical Personnel**

1. EMS personnel shall honor a conscious patient's right to give or deny consent for treatment, whether or not the request revokes or contradicts a DNR Order or Advance Directive based on informed consent.
2. EMS personnel shall provide comfort care to persons who have chosen not to be resuscitated.
3. EMS personnel shall not initiate cardiopulmonary resuscitation (CPR) or other resuscitation treatments for patients with apparently valid DNR Orders or DNR Identification.
4. Even if a patient is being taken to an out of state hospital, Vermont law (statutes and rules) on advance directives applies to the call and transport while the patient is in Vermont.
5. No local variations are allowed with regard to advance directives and DNRs.
6. These rules apply to all EMS work, including in-hospital and interfacility transfers.

### **VII Experimental Treatments**

1. A principal may authorize participation in treatment studies or drug trials, or may authorize the principal's agent to consent to treatment studies or drug trials, as part of health care provided pursuant to an advance directive as defined in 18 VSA § 9701(11).
2. An advance directive may not substitute for compliance with 21 C.F.R. Part 56, 21 C.F.R. Part 312, or any other applicable state or federal law, and treatment studies or drug trials may not be included within a waiver of the right to object to treatment under 18 VSA § 9707(h).

### **VIII Advance Directive Registry**

#### **A. The Registry**

1. The Vermont Advance Directive Registry (VADR) is a secure, web-based database to which individuals may submit, at no charge, an advance directive or an Advance Directive Locator (information regarding the location of an advance directive), and other documents which amend, suspend, or revoke an advance directive.
2. VADR is a voluntary database. Registrants who voluntarily use the VADR system have a responsibility to keep the VADR system informed and updated about any changes to their Advance Directive. This responsibility is important because medical providers and facilities are required to access the VADR system for information about a person's Advance Directive, and information obtained from VADR is presumed to be current and accurate absent any evidence to the contrary.
3. VADR serves only as a repository of information and documents and will not evaluate the validity of, or reconcile, documents except to determine whether the Registration Agreement is complete.
4. Information regarding the Vermont Advance Directive Registry can be obtained from the Department of Health, PO Box 70, 108 Cherry Street, Burlington, VT 05402-0070, on the Department's website (<http://healthvermont.info/vadr>), or at 1-800-548-9455.

#### **B. Submissions to VADR**

1. Any individual may submit a copy of an advance directive or Advance Directive Locator, and an original Registration Agreement for entry into the registry by mailing or faxing those documents to VADR.
2. Attachments C and D are the Registration Agreement and the Advance Directive Locator.
3. VADR shall scan into the registry the advance directive, regardless of form or content, or the Advance Directive Locator.
4. VADR shall send to the registrant, by mail, confirmation of the submission, a unique identification number, a wallet card and stickers with VADR contact information, and instructions for accessing VADR and viewing the file.

#### **C. Amendment, Suspension, and Revocation of an Advance Directive by the Registrant**

1. A registrant may file an amendment, suspension, or revocation of an advance directive at any time by notifying VADR in writing with the registrant's identification number or sufficient information to identify the registrant.

2. A registrant who wishes to file an amendment to, or suspend or revoke an advance directive, may use the Authorization to Change form provided in Attachment E.
3. In order for an amendment to have the same legal effect as the advance directive, the amendment must be properly executed as if it were a new advance directive.
4. Annually, VADR will mail a notice to each registrant requesting review and confirmation that the information on file is accurate and current.
5. Upon receiving notice of an amendment, suspension, or revocation, or information in response to VADR's annual mailing, VADR shall scan the document into the registrant's file in a manner that will present it to an accessor so that it appears before previously submitted documents.
6. Failure to notify VADR of an amendment, suspension, or revocation of an advance directive does not affect the validity of the amendment, suspension, or revocation of the advance directive.

#### **D. Notifying the Registry of Amendment, Suspension, and Revocation of an Advance Directive**

##### **1. Health Care Providers, Health Care Facilities, and Residential Care Facilities**

**a. Incapacitated patient:** Any health care provider, health care facility, or residential care facility who becomes aware of an amendment, suspension, or revocation of a registrant's advance directive while treating an incapacitated patient, shall make reasonable efforts to notify VADR of the amendment, suspension, or revocation by completing and sending a Provider Notification, if the patient's advance directive has been submitted to the registry.

**b. Patient with capacity:** Any health care provider, health care facility, or residential care facility who becomes aware of an amendment, suspension, or revocation of a registrant's advance directive while treating a patient with capacity, on request shall assist the patient in notifying VADR of the amendment, suspension, or revocation, if the patient's advance directive has been submitted to the registry.

**c. Patient not currently receiving health or residential care:** Any health care provider, health care facility, residential care facility, not currently providing health or residential care to a registrant, which becomes aware of an amendment, suspension, or revocation of a registrant's advance directive shall ensure that VADR is notified of the amendment, suspension, or revocation by completing and sending a Provider Notification, if the patient's advance directive has been submitted to the registry.

2. **Agent/Guardian:** An agent or guardian who becomes aware of an amendment, suspension, or revocation of a registrant's advance directive

shall make reasonable efforts to notify VADR of the amendment, suspension, or revocation by completing and sending an Agent/Guardian Notification, if the patient's advance directive has been submitted to the registry.

3. Upon receipt of a Provider Notification or Agent/Guardian Notification, VADR will scan the document into the registrant's file, placing it before previously submitted documents.
4. Attachments F and G are the Provider Notification and Agent/Guardian Notification forms, respectively.
5. Failure to notify VADR of an amendment, suspension, or revocation of an advance directive does not affect the validity of the amendment, suspension, or revocation of the advance directive.
6. A health care provider, health care facility, or residential care facility which, in the course of providing treatment, checks the registry and finds a Provider or Agent/Guardian Notification of Change form shall make reasonable efforts to determine the wishes of the registrant. Consistent with 18 V.S.A. § 9713, the provider or facility shall not be subject to criminal or civil liability for providing or withholding health care or services in good faith pursuant to the Advance Directive or Notification of Change.

#### **E. Deletion or Replacement of an Advance Directive in the Registry**

1. A registrant may delete a file in the registry by submitting to VADR an Authorization to Change or sufficient information to identify the registrant and a clear statement that the registrant wishes to delete the existing file.
2. A registrant may replace his or her existing file in the registry by submitting to VADR a properly executed advance directive accompanied by an Authorization to Change or sufficient information to identify the registrant and a clear statement that the registrant wishes to replace the existing forms.

#### **F. Access to the Registry**

1. No person shall access VADR information for any purpose unrelated to decision-making for health care or disposition of remains of the registrant, except that the Department may authorize specific persons to access the information for statistical or analytical purposes as long as registrants' identifying information remains confidential.
2. Advance directives and other forms submitted to the registry can be accessed at: <http://healthvermont.gov/vadr> by using the unique registration identification number issued to the registrant by the VADR.
3. Agents, guardians, persons appointed to arrange for the disposition of



remains, or any person to whom the registrant has given the registrant's identification number and authority to access the file can access the registrant's file by using the registrant's identification number.

4. An agent, guardian, or person appointed to arrange for the disposition remains who does not have a registrant's identification number may obtain a copy of the file by calling VADR's toll-free number to request a copy of the advance directive for a specific registrant.
5. Providers can access documents submitted to the registry by:
  - a. becoming an authorized provider by submitting a completed Provider Access Application and Provider Access Agreement to VADR c/o the Department of Health at 108 Cherry St., Burlington, VT 05401. Once the application is approved, VADR will issue a provider identification number and access code;
  - b. using the registrant's identification number; or calling VADR's toll-free number to request a copy of a registrant's document.
6. VADR shall maintain a record by name of registrant, date and identification number of the person or organization that accessed the registrant's file whenever a file is accessed.

#### **G. Obligations of Providers**

1. Providers who are issued a registry account shall agree to protect the identification number issued to the provider and to limit access to the identification number to their employees with a need to access the registry.
2. Providers who are issued a registry account shall train their employees on the proper use of the registry and the registrants' documents, and the obligation to report any unauthorized access or misuse of information to the Department.

### **IX Authority and Obligations of Health Care Providers, Health Care Facilities and Residential Care Facilities and Health Insurers**

1. Health care providers, health care facilities, and residential care facilities and their staff members shall comply with the requirements of 18 V.S.A. Chapter 231 with regard to:
  - a. obtaining and following the health care instructions of a patient (18 V.S.A. §§ 9707(a), (b), (g) and (h), 9708 (c), 9709(a), 9714);
  - b. communicating with the patient, agent, guardian or other persons identified by the patient (18 V.S.A. §§ 9702 (a)(9), 9704, 9706, 9707(c), 9708);
  - c. recording the basis for all significant decisions in the patient's medical record, including the basis for believing a patient wants to suspend or

revoke a DNR Order or Identification based on informed consent (18 V.S.A. §§ 9704, 9706-08);

- d. assisting the patient to execute an advance directive (18 V.S.A. §§ 9703, 9709); and
  - e. assisting the patient, agent or guardian in obtaining care (18 V.S.A. § 9707), or submitting documents to VADR (18 V.S.A. §§ 9704, 9707).
2. Health care providers, health care facilities, and residential care facilities shall adopt and follow all protocols required under 18 V.S.A. § 9709(a).
  3. Health care facilities and residential care facilities shall adopt and follow all protocols required under 18 V.S.A. § 9709(b).
  4. Every hospital shall designate an adequate number of individuals to explain the nature and effect of an advance directive to patients as required by 18 V.S.A. § 9709(c).
  5. No health care provider, health care facility, residential care facility or health insurer shall discriminate in rates or offering services or insurance on the basis of a person's advance directive or DNR order in violation of 18 V.S.A. § 9709(d).

**X Authority and Obligations of Funeral Directors, Crematory Operators, Cemetery Officials, Procurement Organizations, and Persons appointed to arrange for the Disposition of the Principal's Remains**

1. Funeral Directors, Crematory Operators, Cemetery Officials, Procurement Organizations, and Persons appointed to arrange for the disposition of the principal's remains shall determine and follow the principal's instructions, with limited exceptions. (18 V.S.A. § 9712(a), (b) and (c)).
2. Funeral Directors, Crematory Operators, Procurement Organizations and Cemetery Officials shall develop the systems required by 18 V.S.A. § 9712(d).

# Vermont Advance Directive for Health Care

## — LONG FORM —

### EXPLANATION AND INSTRUCTIONS

**A**n Advance Directive is a document you prepare to choose someone as your health care agent or to guide others to make health decisions for you. An advance directive can include instructions about your health care as well as what should happen with your body after you die. Having an Advance Directive helps when you no longer can or no longer wish to make your own decisions. As you begin your Advance Directive, here are some important things to know:

- You have the right to consent to or refuse any medical treatment.
- You have the right to appoint an **agent** to make decisions for you.
- You may use this Advance Directive to share your wishes *in advance*.
- You may fill out all Parts of this Advance Directive form or just portions of it. For example, you can just appoint an agent in Part 1 and then sign Part 9. If you choose not to appoint an agent, you can skip part 1 and just give instructions in other Parts that you wish to fill out. However, if you fill out any Part of this document, you must also fill out Part 9, as it provides signatures and witnesses to validate the Advance Directive.
- You may use any Advance Directive form or format as long as it is properly signed and witnessed.
- You can revoke or suspend your Advance Directive at any time unless you expressly waive your right to do so.

**Everyone could benefit from having an Advance Directive** — not just those anticipating the end of their lives. Any of us could have an accident or suffer from an unexpected medical condition. Some of us live with a mental or physical illness that leaves us without capacity at times. Without an Advance Directive, those making decisions for you will not know what your wishes are. Worse still, your family and friends could fight over the care you should get. Help them help you — fill out and sign an Advance Directive.

**This Advance Directive has 9 Parts.** Fill out as few or as many Parts as you like today. If you want, you can fill out other Parts another day. This is *your* document: change it as you like so that it states your wishes in your own words. You may cross out what you don't like and add what you want.

*Note: For copying and storing purposes only the actual form pages, not the instructions, have consecutive page numbers. When sending copies, you need send only the numbered pages of the form itself.*

## **Updating your Advance Directive**

It is very important that the information in your Advance Directive is always current. Review it once a year or when events in your life change. Consider the "5 D's" as times when your Advance Directive might need to be changed or updated. The 5 D's are: Decade birthday, Diagnosis, Deterioration, Divorce or Death of somebody close to you or that affects you. All of these events may affect how you think about future health care decisions for yourself.

Whenever necessary, you should also update addresses and contact information for your agent and alternate agent and other people such as potential medical guardians whom you may have identified in your Advance Directive.

## **Revoking or Suspending your Advance Directive**

You may revoke your Advance Directive by completing a new Advance Directive or completing replacement Parts of this Advance Directive. Then the old Advance Directive or Part is no longer in effect and the new one replaces it. If the new one and the old one cover different subjects, then both will be in effect.

Suspending an Advance Directive is when you want a provision to not be in effect for a period of time. For example, you may have said you wanted a DNR order and the order may have been given to you. Then you need to go in for surgery and want the understanding that you will be revived during surgery if your heart stops.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;
2. Personally informing your doctor and having him or her note that on your record;
3. Burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present; or
4. For any provision (other than designation of your agent), stating orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive.

## Appointment of My Health Care Agent

Appointing an agent to make decisions for you may be the single most important part of your Advance Directive. Your agent must be at least 18 years old and should be someone you know and trust. The person you choose should be someone who can make decisions for you, based upon your wishes and values. You **cannot** appoint your doctor or other health care clinician to be your agent. If you are in a nursing home or residential care facility, staff or owners cannot be your agents unless they are related to you. You can appoint an **alternate agent** to make decisions for you if your original agent is unavailable, unable, or unwilling to act for you. You can also appoint co-agents if you wish. (If you appoint co-agents, use the second page of Part 1 of this form.)

The authority of your agent to make decisions for you can begin:

- when you no longer have the **capacity** to make decisions for yourself, such as when you are unconscious or cannot communicate, or
- **immediately** upon signing the advance directive *if you so specify*, or
- when a **condition** you specify is met, such as a diagnosis of a debilitating disease such as Alzheimer's Disease or serious mental illness, or
- when an **event** occurs that you want to mark the start of your agent's authority, such as when you move to a nursing home or other institution.

The authority of your agent will **end** when you regain capacity to make your own decisions or you may specify when you want your Advance Directive to be no longer in effect.

Once your Advance Directive goes into effect, your agent will have access to all your medical records and to persons providing your care. *Unless you state otherwise* in written instructions, your agent will have the same authority to make all decisions about your health care as you have.

Your agent will be obligated to follow your instructions when making decisions on your behalf to the extent that they apply. If you choose not to leave explicit written directions in other Parts of your Advance Directive, the persons making health care decisions for you will be guided by knowledge of your values and what is in your best interest at the time treatment is needed.

# Advance Directive

MY NAME ..... DATE OF BIRTH ..... DATE SIGNED.....

ADDRESS .....

CITY..... STATE ..... ZIP.....

PHONE ..... EMAIL.....

## PART 1: MY HEALTH CARE AGENT

1. I want my agent to make decisions for me: (choose one statement below\*)
- \_\_\_\_\_ when I am no longer able to make health care decisions for myself, or
- \_\_\_\_\_ immediately, allowing my agent to make decisions for me right now, or
- \_\_\_\_\_ when the following condition or event occurs (to be determined as follows):

*\*Normally these statements are separate choices, but it is conceivable that they could be concurrent.*

2. I appoint \_\_\_\_\_ as my health care Agent to make any and all health care decisions for me, except to the extent that I state otherwise in this Advance Directive. (You may cross out the italicized phrase if authority is unrestricted.)

Address: \_\_\_\_\_

Relationship (optional): \_\_\_\_\_

Tel. (daytime): \_\_\_\_\_ (evening): \_\_\_\_\_

cellphone: \_\_\_\_\_ email: \_\_\_\_\_

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint \_\_\_\_\_ to be my Alternate Agent.

Address: \_\_\_\_\_

Relationship (optional): \_\_\_\_\_

Tel. (daytime): \_\_\_\_\_ (evening): \_\_\_\_\_

cellphone: \_\_\_\_\_ email: \_\_\_\_\_

And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint \_\_\_\_\_ as my Next Alternate Agent.

Address: \_\_\_\_\_

Relationship (optional): \_\_\_\_\_

Tel. (daytime): \_\_\_\_\_ (evening): \_\_\_\_\_

cellphone: \_\_\_\_\_ email: \_\_\_\_\_

4. \_\_\_\_\_ I want to appoint two or more people to be co-agents and have listed them on page two of this Part.

## Appointment of "co-agents"

You can appoint co-agents — people you ask to make decisions for you, acting together, based upon a discussion of your circumstance and agreement on a course of action or treatment. Sometimes co-agents have difficulty making decisions together. Before completing this part, be sure this is the best choice for you and your co-agents.

Not all of the people you ask to be co-agents may be readily available to speak for you or to make decisions that have to be made immediately, particularly in an emergency. For this reason, it is a good idea to give additional directions about how decisions can be made by your co-agents.

### 5. Co-agents I appoint are:

Name: \_\_\_\_\_ Relationship (optional): \_\_\_\_\_

Address: \_\_\_\_\_

Phone (specify work, home or cell): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship (optional): \_\_\_\_\_

Address: \_\_\_\_\_

Phone (specify work, home or cell): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship (optional): \_\_\_\_\_

Address: \_\_\_\_\_

Phone (specify work, home or cell): \_\_\_\_\_

(repeat below for additional co-agents)

### 6. I prefer that decisions made by the co-agents named above be made in the following way (you may choose one or prioritize 1,2,3):

\_\_\_\_\_ by agreement of all co-agents

\_\_\_\_\_ by a majority of those present, or

\_\_\_\_\_ by the first person available, if it is an emergency.

### 7. Other Instructions for co-agents (optional):

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## Others who may be involved in my care.

**Part 2** is where you can list your current doctor or clinician with address and phone number. This will help by identifying someone who knows your medical history.

You can also state who else should or should **not** be consulted about your care.

You can state who is to be given information about your medical condition. This list might include your children, even if they are minors, or your close friends. Hospitals are required to withhold information about your condition from people unless you or your agent gives permission that this can be shared.

You can state who shall not be able to challenge decisions about your care in court actions. Normally any "interested individual" can bring an action in Probate Court regarding decisions made on your behalf. "Interested individuals" are your spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneficiary, clergy person or any adult who has exhibited special care and concern for you and who is personally familiar with your values. If there is someone in that list that you do **not** want to be able to bring an action to protect you, you may record the name of that person in Part 2.

Sometimes a court appoints a guardian for a person who is unable to manage aspects of his personal care or financial affairs. You can state a preferred person that you would like the court to appoint if this occurs in the future. That person could be the same person you chose as an agent or it could be someone else. You can also identify persons you would **not** want appointed as a future guardian for you.



NAME \_\_\_\_\_

DOB \_\_\_\_\_

DATE \_\_\_\_\_

**PART 2: OTHERS WHO ARE OR MAY BECOME INVOLVED IN MY CARE**

## 1. My Doctor or other Health care Clinician:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

(or)

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

2. Other people whom my agent *may* be consulted about medical decisions on my behalf:\_\_\_\_\_  
\_\_\_\_\_Those who should *not* be consulted by my agent include:\_\_\_\_\_  
\_\_\_\_\_

## 3. My health agent or health care provider may give information about my condition to the following adults and minors:

\_\_\_\_\_  
\_\_\_\_\_

## 4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this Advance Directive nor serve as a health care decision maker for me.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

5. If I need a **guardian** in the future, I ask the court to consider appointing the following person:

\_\_\_\_\_ My health care agent

\_\_\_\_\_ The following person:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_

You may also list alternate preferred guardians, or persons that you would not want to have appointed as guardians.

Alternate preferred guardians: \_\_\_\_\_

Persons I would not want to be my guardian: \_\_\_\_\_

\_\_\_\_\_

## Statement of Values and Goals

**Part 3** allows you to state in your own words what is most important to you as you think about medical care you may receive in the future. This will guide your agent and your health care providers and will let them know why you think particular choices are important based upon your own values and beliefs.

If you choose to fill out this Part, you may wish to use the **Worksheet 1: Values Questionnaire** that is in the Vermont Ethics Network booklet *Taking Steps* for help in framing and sharing your response.

You may also wish to use **Worksheet 2: Medical Situations and Treatment**. The second worksheet helps you consider how you might respond to changing circumstances and the changing chances that medical treatment may be successful.

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

### PART 3: STATEMENT OF VALUES AND GOALS

Use the space below to state in your own words what is most important to you.

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.... And general advice about how to approach medical choices depending upon your current or future state of health or the chances of success of various treatments.

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## End of Life Wishes.

**Part 4** contains statements that you can use to express either a desire for continued treatment or a desire to limit treatment as death approaches or when you are unconscious and unlikely to regain consciousness.

Part 4 allows you to include other things that may be important to you, such as the type of care you would want and where you hope to receive that care if you are very ill or near the end of your life.

There may be other issues about health care when death is not expected or probable. These treatment issues and choices you can address in Parts 5 and 6 if you wish.

There may be questions about your survival that even doctors cannot predict accurately in your case. It is important to repeat that Part 4 is for those situations where you are *not* likely to survive or to continue living without life-sustaining treatment on a long-term basis.

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**PART 4: END-OF-LIFE TREATMENT WISHES**

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose all that apply):

1. \_\_\_\_\_ I **do** want all possible treatments to extend my life.

— or —

2. \_\_\_\_\_ I **do not** want my life extended by any of the following means:

\_\_\_\_\_ breathing machines (ventilator or respirator)

\_\_\_\_\_ tube feeding (feeding and hydration by medical means)

\_\_\_\_\_ antibiotics

\_\_\_\_\_ other medications whose purpose is to extend my life

\_\_\_\_\_ any other means

\_\_\_\_\_ Other (specify) \_\_\_\_\_

3. \_\_\_\_\_ I want my **agent to decide** what treatments I receive, *including tube feeding*.

4. \_\_\_\_\_ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. \_\_\_\_\_ I want **pain medication** to be administered to me even though this may have the *unintended effect* of hastening my death.

6. \_\_\_\_\_ I want **hospice care** when it is appropriate in any setting.

7. \_\_\_\_\_ I would prefer to **die at home** if this is possible.

8. Other wishes and instructions: (state below or use additional pages):

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## Other Treatment Wishes.

**Part 5** addresses situations which may be temporary, long-term or which may be part of a health crisis that might become life ending for you if no treatment was given or if it was unsuccessful.

You may want to state your wishes regarding a **“Do Not Attempt Resuscitation” Order (DNR Order)** if your heart were to stop (statement 1). Such an order must be written and signed by your doctor. Either the completed written order, or a special bracelet or other identification of that order, needs to be available for any emergency first responders who are called to the scene when your heart stops. It is up to you or your agent to make sure that these additional steps are taken, including having your doctor complete and sign the order and give you either a copy of the order or some other identification.

You may be in a situation in which there is a chance for recovery but, without treatment, you might die. Statement 2 is about allowing a **“trial of treatment”** in situations like these. This means you want to start treatments that will sustain your life, such as breathing machines or tube feeding, to see if you will recover. If these life sustaining treatments are not successful after a period of time, you give your agent and other care providers permission to stop or withdraw them.

Other statements in this Part concern your wishes about hospitalization and treatment as well as participation in medical student education, or clinical or drug trials as part of your treatment.

There is also a statement about mental health treatment and your preferences concerning types of involuntary treatment.

Statement 9 of this Part concerns specific directions for prescribing and conducting electro-convulsive therapy (ECT) sometimes called “electro-shock” treatment.

If certain statements of Part 5 do not concern or apply to you, do not feel you have to address them. If you have an agent, that person will make decisions for you should the need arise.

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**PART 5: OTHER TREATMENT WISHES**

1. \_\_\_\_\_ I wish to have a **Do Not Resuscitate (DNR) Order** written for me.
2. \_\_\_\_\_ If I am in a critical health crisis that may not be life-ending and **more time is needed** to determine if I can get better, I want treatments started. If, after a reasonable period of time, it becomes clear that I will **not** get better, I want all life extending treatment **stopped**. This includes the use of breathing machines or tube feeding.
3. If I am conscious but become **unable to think or act for myself** and will likely not improve, I do not want the following life-extending treatment:
  - \_\_\_\_\_ breathing machines (ventilators or respirators)
  - \_\_\_\_\_ feeding tubes (feeding and hydration by medical means)
  - \_\_\_\_\_ antibiotics
  - \_\_\_\_\_ other medications whose purpose is to extend life
  - \_\_\_\_\_ any other treatment to extend my life
  - \_\_\_\_\_ Other: \_\_\_\_\_
4. \_\_\_\_\_ If the likely **costs, risks and burdens** of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are: \_\_\_\_\_
5. \_\_\_\_\_ If it is determined that I am **pregnant** at the time this Advance Directive becomes effective, I want:
  - \_\_\_\_\_ all life sustaining treatment. (or)
  - \_\_\_\_\_ only the following life sustaining treatments:
    - \_\_\_\_\_ breathing machines (ventilators or respirators)
    - \_\_\_\_\_ feeding tubes (feeding and hydration by medical means)
    - \_\_\_\_\_ antibiotics
    - \_\_\_\_\_ other medications whose purpose is to extend life
    - \_\_\_\_\_ any other treatment to extend my life
    - \_\_\_\_\_ Other: \_\_\_\_\_
  - \_\_\_\_\_ No life sustaining treatment
6. **Hospitalization** — If I need care in a **hospital or treatment facility**, the following facilities are listed in order of preference:
 

Hospital/Facility: _____	Tel: _____
Address: _____	_____
Hospital/Facility: _____	Tel: _____
Address: _____	_____
Reason for preference: _____	

I would like to **Avoid** being treated in the following facilities:

Hospital/Facility: _____	Reason: _____
Hospital/Facility: _____	Reason: _____

7. **I prefer the following medications or treatments:** Use more space or additional sheets for this section, if needed.

Avoid use of the following medications or treatments: (List medications/treatments)

Reason: \_\_\_\_\_  
Reason: \_\_\_\_\_

8. **Consent for Student Education, Treatment Studies or Drug Trials**

- \_\_\_\_\_ I **do** / **do not** (*circle one*) wish to participate in student medical education.  
\_\_\_\_\_ I **do** / **do not** (*circle one*) wish to participate in treatment studies or drug trials.  
(or)  
\_\_\_\_\_ I authorize my agent to consent to any of the above.

9. **Mental Health Treatment**

A. **Emergency Involuntary Treatment.** If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order:  
(List by number as many as you choose. For example, 1 = first choice; 2 = second choice, etc.  
You may also note the type of medication and maximum dosage.)

- \_\_\_\_\_ Medication in pill form  
\_\_\_\_\_ Liquid medication  
\_\_\_\_\_ Medication by injection  
\_\_\_\_\_ Physical restraints  
\_\_\_\_\_ Seclusion  
\_\_\_\_\_ Seclusion and physical restraints combined  
\_\_\_\_\_ Other: \_\_\_\_\_

Reason for preferences above (optional): \_\_\_\_\_

B. **Electro-convulsive Therapy (ECT) or "Electro-Shock Treatment":** If my doctor thinks that I should receive ECT and I am not legally capable of consenting to or refusing ECT, my preference is indicated below:

- \_\_\_\_\_ I **do NOT** consent to the administration of any form of ECT.  
\_\_\_\_\_ I **consent** / **do not consent** (*circle one*) to unilateral ECT  
\_\_\_\_\_ I **consent** / **do not consent** (*circle one*) to bifrontal ECT  
\_\_\_\_\_ I **consent** / **do not consent** (*circle one*) to bilateral ECT  
\_\_\_\_\_ I **consent** (or authorize my agent to consent) to ECT as follows:  
\_\_\_\_\_ I agree to the number of treatments the attending Psychiatrist considers appropriate.  
\_\_\_\_\_ I agree to the number of treatments Dr. \_\_\_\_\_ considers appropriate.  
\_\_\_\_\_ I agree to the number of treatments my agent considers appropriate.  
\_\_\_\_\_ I agree to no more than the following number of treatments \_\_\_\_\_.

Other instructions regarding the administration of ECT:

- \_\_\_\_\_ I acknowledge that I and my agent have been apprised of and will follow the uniform informed consent procedures and the use of standard forms to indicate consent to ECT per 18 V.S.A. 7408.



## Waiver of Right to Request or Object to Treatment

**Part 6** is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored. **You must have an agent to fill out this Part.**

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded*. If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say "no" when it is offered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Part will help you let your agent, and others know what you *really* want for yourself.

Because this is signing away a basic right that all patients have (to refuse or to request treatment) unless a court orders otherwise, you will need to give this much careful thought. You will also have to have additional signatures and assurances at the time you fill out this Part of your Advance Directive.

If you think Part 6 could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramifications of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke Part 6 ***only when you have capacity to make medical decisions*** as determined by your doctor and another clinician.

**For your agent to be able to make healthcare decisions over your objection, you must:**

- \* Name your agent who is entitled to make decisions over your objection: \_\_\_\_\_;
- Specify what treatments you are allowing your agent to consent to or to refuse over your objection;
- State that you either do or do not desire the specified treatment even over your objection at the time and, further, specify your wishes related to voluntary and involuntary treatment and release from that treatment or facility;
- Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive specified treatment at a time of incapacity;
- Have your agent agree in writing to accept the responsibility to act over your objection;
- Have your clinician affirm in writing that you appeared to understand the benefits, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and
- Have an **ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee** affirm in writing that he or she has explained the nature and effect of this provision to you and that you appeared to understand this explanation and be free from duress or undue influence.

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**PART 6: WAIVER OF RIGHT TO REQUEST OR OBJECT TO FUTURE TREATMENT**

I hereby give my agent \_\_\_\_\_ the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I do want** the following treatment to be provided, even over my objection, at the time the treatment is offered: \_\_\_\_\_

**I do not want** the following treatment, even over my request for that treatment, at the time the treatment is offered: \_\_\_\_\_

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.

\_\_\_\_\_ Yes \_\_\_\_\_ No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.

\_\_\_\_\_ Yes \_\_\_\_\_ No

4. I hereby affirm that I am knowingly and voluntarily waiving the right to refuse or request specified treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signed: \_\_\_\_\_, Principal Date: \_\_\_\_\_

*(Continued next page)*

## Acknowledgements

**Acknowledgement by Agent** — I hereby accept the responsibility of consenting to or refusing the treatments specified above, even if to do so would be against the principal's expressed wishes at the time treatment is considered.

Signed: (Agent) \_\_\_\_\_ and (Alternate) \_\_\_\_\_

Print names: \_\_\_\_\_

Phone: \_\_\_\_\_

Date: \_\_\_\_\_

**Acknowledgement of principal's clinician** — I affirm that the principal appears to understand the benefits, risks, and alternatives to the health care specified above that is being consented to or refused by the principal.

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

Facility: \_\_\_\_\_ Date: \_\_\_\_\_

Please print name: \_\_\_\_\_

**Acknowledgement by persons who explain Part 6** — I, as the designated person to explain Part 6, affirm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

- Explained the nature and effect of this Waiver of the Right to Request or Object to Treatment to the principal, and
- The principal appears both to understand the nature and effect of this provision and to be free from duress or undue influence.
- If the principal is in a hospital at the time of signing, that I am not affiliated with that hospital; and
- I am not related to the principal, a reciprocal beneficiary, or the principal's clergy or a person who has exhibited special care and concern for the principal.

Signed: \_\_\_\_\_

Position: \_\_\_\_\_ Date: \_\_\_\_\_

## Organ and Tissue Donation

**Part 7** of your Advance Directive allows you to state your wishes about organ and tissue donation.

In our country permission for organ donation is not assumed and often the family or next of kin are approached for donation at the time of an accidental or unexpected death. Although you may elect to have an agent or your family decide on organ and tissue donation, your organs are more likely to be used if you make the decision yourself.

You may also note your wishes on your license and attach the sticker showing that you wish to be an organ donor. You do not have to have an Advance Directive form filled out to show evidence of your wishes to be an organ donor, particularly if your license identification includes your wishes about organ donation.

If you wish to donate your body for research to a medical school you will first need to contact that institution to make separate arrangements and fill out forms supplied by that institution.

NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**PART 7: ORGAN AND TISSUE DONATION**

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. *(Initial below all that apply.)*

\_\_\_\_\_ I wish to donate the following organs and tissues:

\_\_\_\_\_ any needed organs or tissues

\_\_\_\_\_ major organs (heart, lungs, kidneys, etc.)

\_\_\_\_\_ tissues such as skin and bones

\_\_\_\_\_ eye tissue such as corneas

\_\_\_\_\_ I wish my agent to make any decisions for anatomical gifts (or)

\_\_\_\_\_ I wish the following person(s) to make any decisions:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

\_\_\_\_\_ I do not wish to be an organ donor.

## Disposition of My Body after Death

**Part 8** allows you to give directions about funeral arrangements or related wishes about the final disposition of your body after you die.

You can use the section to appoint an agent for making these arrangements, or you may say that family members should decide. You can give directions to whoever is in charge.

You can list important information about any pre-need arrangements you have made with a funeral home or cremation service or about the location of family burial plots.

You may indicate your permission to have an autopsy done on your body after your death. An autopsy is generally not suggested or needed when the cause of death is clear. If an autopsy is suggested, it could be helpful to your agent or family to know your wishes about having an autopsy performed. Autopsies may be *required* in cases where abuse, neglect, suicide or foul play is suspected.

NAME \_\_\_\_\_

DOB \_\_\_\_\_

DATE \_\_\_\_\_

**PART 8: MY WISHES FOR DISPOSITION OF MY BODY AFTER MY DEATH**

## 1. My Directions for Burial or Disposition of My Remains after Death.

\_\_\_\_\_ I want a funeral followed by burial in a casket at the *following location, if possible*  
(please tell us where the burial plot is located and whether it has been pre-purchased):

(or)

\_\_\_\_\_ I want to be cremated and want my ashes buried or distributed as follows:

(or)

\_\_\_\_\_ I want to have arrangements made at the direction of my agent or family.

Other instructions: \_\_\_\_\_

*(For example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)*

2. **Agent** for disposition of my body (*select one*):

\_\_\_\_\_ I want my **health care agent** to decide arrangements after my death;  
if he or she is not available, I want my alternate agent to decide.

\_\_\_\_\_ I appoint the following person to decide about and arrange for the disposition of my body after my death:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Cellphone: \_\_\_\_\_

Email: \_\_\_\_\_

(or)

\_\_\_\_\_ I want my family to decide.

3. If an **autopsy** is suggested following my death:

\_\_\_\_\_ I support having an autopsy performed.

\_\_\_\_\_ I would like my agent or family to decide whether to have it done.

4. I have already made **funeral or cremation arrangements** with:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

## Signature and Witnesses

Congratulations! You have done much good work in sharing your wishes through the completion of your Advance Directive.

Be sure that your wishes as stated in the Parts you have chosen to fill out make sense when read together as a whole. If there is a question of conflicting wishes, be sure that you have indicated your priorities.

When you sign your Advance Directive, you must have **two adult witnesses**. Neither witness can be your spouse, agent, brother, sister, child, grandchild or reciprocal beneficiary. A change in Vermont law has made it a little easier to have witnesses available to assist you. For example, your health care or residential care provider and their staff now can be witnesses of Advance Directives.

If you are in a hospital, nursing home or residential care facility when you complete your Advance Directive, you will need a third person's signature to certify that he or she has explained the Advance Directive to you and that you understand the impact and effect of what you are doing. In a health care facility, this third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson or a Probate Court designee. (Note: If you decide to include **Part 6** when you are in a health care facility, you must be sure that the third person who signs your document in that Part is not affiliated with or employed by the health care facility.)

## Distribution of Copies of this Document

It is a good idea to make sure that your agent, your family, your personal physician and your nearest hospital or medical facility all have copies of this Advance Directive. List the people to whom you give copies at the end of Part 9 of the Advance Directive form. This will make it easy for you to remember to tell all of these people if you decide to cancel, revoke or change this document in the future.

By mid-2007 you will also have the option to have your advance directive scanned into an electronic databank called an **Advance Directive Registry** where you, your agent, your health care facility and others you designate, can get copies of your advance directive (including special personal handwritten instructions) immediately.



NAME \_\_\_\_\_ DOB \_\_\_\_\_ DATE \_\_\_\_\_

**PART 9: SIGNED DECLARATION OF WISHES**

**I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death,) and that I am signing this Advance Directive of my own free will.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(Optional)* I affirm that I have given or will give copies of my Advance Directive to my Agent(s) and Alternate Agent(s) and that they have agreed to serve in that role if called upon to do so.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*(Optional)* I affirm that I have given or will give a copy of my Advance Directive to my Doctor or Clinician.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Acknowledgement of Witnesses** — I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**Acknowledgement by the person who explained this Advance Directive if the principal is a current patient or resident in a hospital, or other health care facility.**

I affirm that:

- the maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Name: \_\_\_\_\_ Title/position: \_\_\_\_\_

Address: \_\_\_\_\_

Tel.: \_\_\_\_\_ Date: \_\_\_\_\_

***Important!***

Please list below the people and locations that will have a copy of this document:

\_\_\_\_\_ **Vermont Advance Directive Registry** (anticipated available by mid- 2007)

\_\_\_\_\_ **Health care agent(s)**

\_\_\_\_\_ **Alternate health care agent**

\_\_\_\_\_ **Family members:** (List by name all who have copies)

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ MD (Name) \_\_\_\_\_ Address \_\_\_\_\_

\_\_\_\_\_ Hospital (s) (Names) \_\_\_\_\_

\_\_\_\_\_ Other individuals or locations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**INSTRUCTIONS FOR CLINICIANS**  
**COMPLETING VERMONT DNR/COLST FORM**  
**(DO NOT RESUSCITATE ORDER/CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)**

**Completing DNR/COLST**

- The DNR/COLST form must be completed and signed by a health care clinician based on patient preferences and medical indications. A clinician is defined as a medical doctor, osteopathic physician, advance practice registered nurse or physician assistant. 18 V.S.A. § 9701(4). Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/community policy.
- Photocopies and Faxes of signed COLST forms are legal and valid; use of original is encouraged.

**Special requirements for completing the DNR section of COLST (18 V.S.A. §9708)**

- A DNR order may be written on the basis of either informed consent or futility. Complete section A-2 for informed consent; Section A-3 for futility.
- An order based on informed consent must include the name of the individual giving informed consent.
- An order based on futility must include a certification by the clinician and a second clinician that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.
- If patient is in a health care facility, the clinician must certify that the facility's DNR policy has been followed
- The clinician may authorize the issuance of a DNR identification to the patient
- Clinician must certify that clinician has consulted or made an attempt to consult with the patient, and the patient's agent or guardian.

**Using DNR Order - Section A CPR/DNR - 18 V.S.A. § 9708(c)**

- A DNR Order (Section A of the DNR/COLST form) only precludes efforts to resuscitate in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient. (Sections B through H of the COLST Form address other interventions.)
  - Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR Identification unless the professional or facility believes in good faith, after consultation with the patient, agent or guardian, where possible and appropriate
    - that the patient wishes to have the DNR Order revoked if the Order is based on informed consent, or
    - that the patient with the DNR identification or order is not the individual for whom the DNR order was issued.
- Documentation of basis for belief in medical record is required.

**Using COLST (Sections B through H)**

- Any section of COLST not completed indicates that the COLST order does not address that topic. It may be addressed in a patient's advance directive, or in other parts of the medical record.
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only", may be transferred to a setting able to provide comfort.
- Treatment of dehydration is a measure that may prolong life. For a patient who desires IV fluids the order should indicate "Limited Interventions" or Full Treatment."
- A patient with or without capacity, or another person authorized to provide consent, may revoke the COLST order at any time and request alternative treatment. Exceptions may apply. See, 18 V.S.A. § 9707(h) or 18 V.S.A. § 9707(g).
- Photocopies and faxes of signed DNR/COLST forms are legal and valid; use of original is encouraged.

**Reviewing DNR/COLST**

This form should be reviewed periodically and a new form completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change, or
4. At least annually, but more frequently in residential or inpatient settings.

**Voiding DNR/COLST**

To void this form or a part of it, draw a line through each page or section to be voided and write "VOID" in large letters.



**DNR/COLST  
CLINICIAN ORDERS**

**for DNR/CPR and OTHER LIFE SUSTAINING TREATMENT**

Patient Last Name
Patient First/Middle Initial
Date of Birth

FIRST follow these orders, THEN contact Clinician.

(If patient/resident has no pulse and/or no respirations)

<b>A</b>	 <b>DO NOT RESUSCITATE (DNR)</b> 	<b>CARDIOPULMONARY RESUSCITATION (CPR)</b>
	<input type="checkbox"/> DNR/Do Not Attempt Resuscitation (Allow Natural Death)	<input type="checkbox"/> CPR/Attempt Resuscitation

For patient who is breathing and/or has a pulse GO TO SECTION B - C PAGE 2 FOR OTHER INSTRUCTIONS. CLINICIANS MUST COMPLETE SECTIONS A-1 THROUGH A-5

**A-1 Basis for DNR Order**  
Informed Consent - Complete Section A-2  
Futility - Complete Section A-3

**A-2 Informed Consent**  
Informed Consent for this DO NOT RESUSCITATE (DNR) Order has been obtained from:

_____ Name of Person Giving Informed Consent (Can be Patient)	_____ Relationship to Patient (Write "self" if Patient)
_____ Signature (If Available)	

**A-3 Futility (required if no consent)**

☐ I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

_____ Name of Other Clinician Making this Determination (Print here)	_____ Signature of Other Clinician
Dated: _____	

**A-4 Facility DNR Protocol (required if applicable)**

This patient is ☐ is not ☐ in a health care facility or a residential care facility.

Name of Facility: \_\_\_\_\_

If this patient is in a health care facility or a residential care facility, the requirements of the facility's DNR protocol have been met. \_\_\_\_\_ (Initial here if protocol requirements have been met.)

**A-5 DNR Identification (optional)**

I have authorized issuance of a DNR Identification (ID) to this patient. Form of ID: \_\_\_\_\_

<b>Certification and signature for DNR</b>	<b>A-6 Clinician Certifications and Signature for CPR/DNR (required)</b> I have consulted, or made an effort to consult with the patient and the patient's agent or guardian.
	Patient's Agent or Guardian _____ Address or Phone _____
	I certify that I am the clinician for the above patient, and I certify that the above statements are true.
	_____ Signature of Clinician
	_____ Printed Name of Clinician

Dated: \_\_\_\_\_

## ORDERS FOR OTHER LIFE-SUSTAINING TREATMENT

(If patient/resident is breathing and/or has pulse)

**B INTUBATION AND MECHANICAL VENTILATION INSTRUCTIONS:**If patient has DNR order and has progressive or impending pulmonary failure without acute cardiopulmonary arrest:

- ☐ Do Not Intubate/Multi-Lumen Airway (DNI)
- ☐ Trial Period of Intubation/Multi-Lumen Airway and ventilation
- ☐ Intubation/Multi-Lumen Airway and long-term mechanical ventilation if needed

**C TRANSFER TO HOSPITAL**

- ☐ Do not transfer unless comfort care needs cannot be met in current location or if severe symptoms cannot be otherwise controlled
- ☐ Transfer

**D ANTIBIOTICS**

- ☐ No antibiotics. Use other measures to relieve symptoms
- ☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal
- ☐ Use antibiotics

**E ARTIFICIALLY ADMINISTERED NUTRITION:** Offer food and liquids by mouth if feasible.**Feeding tube**

- ☐ No feeding tube
- ☐ Trial period of feeding tube (Goal: \_\_\_\_\_)
- ☐ Long-term feeding tube

**Parenteral nutrition or hydration (e.g. IV fluids or Total Parenteral Nutrition)**

- ☐ No parenteral nutrition or hydration
- ☐ Trial period of parenteral nutrition or hydration (Goal: \_\_\_\_\_)
- ☐ Long term parenteral nutrition or hydration

**F MEDICAL INTERVENTIONS:**

- ☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. Offer food and fluids by mouth, if feasible.
- ☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatments and IV fluids as indicated. *Avoid intensive care if possible.*
- ☐ **FULL TREATMENT** Includes care described above. Use defibrillation and intensive care as indicated.

**G Other Instructions**


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**H Informed Consent and Clinician Signature for COLST Order (Sections B through G)**

Informed Consent for this COLST Order has been obtained from:

\_\_\_\_\_  
Name of Person Giving Informed Consent  
(Patient if competent)

\_\_\_\_\_  
Relationship to Patient  
(Write "self" if Patient)

\_\_\_\_\_  
Signature

**Clinician Signature for COLST**

\_\_\_\_\_  
Signature of Clinician

\_\_\_\_\_  
Printed Name of Clinician

Dated: \_\_\_\_\_

Print Clinician Name	Clinician Signature (mandatory)	Phone Number
Person providing consent's signature (if available)		Date

**Other Contact Information (Optional)**

Name of Guardian, Agent or other Contact Person	Relationship	Phone Number	
Name of Health Care Professional Preparing Form	Preparer Title/Facility	Phone Number	Date Prepared

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> New form completed <input type="checkbox"/> Form Voided
			<input type="checkbox"/> No Change <input type="checkbox"/> New form completed <input type="checkbox"/> Form Voided
			<input type="checkbox"/> No Change <input type="checkbox"/> New form completed <input type="checkbox"/> Form Voided

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED  
GIVE COPY TO PATIENT AND REPRESENTATIVE

**Vermont Advance Directive Registry**  
**REGISTRATION AGREEMENT**  
**VERMONT DEPARTMENT OF HEALTH SOURCE CODE: 53101301**

Registry Use Only

Received:

Confirmed:

1. Read the *Registration Policy*, and complete this *Registration Agreement*. Please type or print clearly. Be sure to sign and date the form.
  2. Attach either a copy of your advance directive, or optionally, an *Advance Directive Locator* form which indicates only the physical location of your advance directive so that it can be retrieved.
  3. Registrations **MUST** include a completed and signed *Registration Agreement* form, and a copy of your advance directive document.
  4. MAIL to: Vermont Advance Directive Registry (VADR)  
523 Westfield Ave., PO Box 2789  
Westfield, NJ 07091-2789
  5. OR FAX to: 908-654-1919
- For forms, or additional information visit: <http://healthvermont.gov/vadr/> or call 1-800-548-9455

**Registrant**

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Suffix \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ Date of Birth (MM/DD/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Mailing Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work ( ) \_\_\_\_\_ - \_\_\_\_\_ Other ( ) \_\_\_\_\_ - \_\_\_\_\_

Secondary Mailing Address: \_\_\_\_\_ Apt # \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Emergency Contacts**

Primary: Name \_\_\_\_\_ Relationship to Registrant: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work/Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

Secondary: Name \_\_\_\_\_ Relationship to Registrant: \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ - \_\_\_\_\_ Work/Other: ( ) \_\_\_\_\_ - \_\_\_\_\_

Does your advance directive make you an organ donor? (Circle one) YES NO

I, \_\_\_\_\_ (print name) request that my advance directive be registered in the Vermont Advance Directive Registry, and authorize its access as allowed by Vermont law. By signing below, I acknowledge and affirm that: the information provided is accurate; I have read, understand, and agree to the terms of the Registry Registration Policy; I will safeguard my registrant identification number and wallet card from unauthorized access; and I will immediately notify the Registry in writing of changes to my registration information or advance directive. I execute this agreement voluntarily and without coercion, duress, or undue influence by any party. I understand that anyone who has access to my wallet card can use it to gain access to my documents and personal information. This authorization remains in effect until I revoke it.

Signature of Registrant: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Attachment C**

## VERMONT ADVANCE DIRECTIVE REGISTRY REGISTRATION POLICY

An advance directive is a legal document that conveys a person's wishes regarding their health care treatment and end of life choices should they become incapacitated or otherwise unable to make those decisions. The Vermont Advance Directive Registry is a database that allows people to electronically store a copy of their advance directive document in a secure database. That database may be accessed when needed by authorized health care providers, health care facilities, residential care facilities, funeral directors, and crematory operators. For more information, visit: <http://healthvermont.gov/vadr/>.

1. To register an advance directive, the registrant must complete and send the *Registration Agreement* form along with a copy of the advance directive to:

The Vermont Advance Directive Registry  
523 Westfield Ave., PO Box 2789  
Westfield, New Jersey 07091-2789.

To register the physical location of the advance directive document, rather than the document itself, the registrant may send the *Advance Directive Locator* form instead of a copy of the advance directive. This form is downloadable from the Registry website.

2. Upon receipt of the *Registration Agreement* and attachments, the Registry will scan the advance directive (or *Advance Directive Locator* form), and store it in the database along with registrant identifying information from the *Registration Agreement*. The Registry will send a confirmation letter to the registrant along with a registration number, instructions for using the registration number to access documents at the Registry website, a wallet card, and stickers to affix to a driver's license or insurance card. The registration is not effective until receipt of the confirmation letter and registration materials is made by registrant.
3. Registrants should share the registration number from the wallet card with anyone that should have access to their advance directives: for example, the registrant's agent, family members, or physician. Anyone may access a person's advance directive using the registration number. Additionally, when the registration number is not readily available, an authorized health care provider can search the Registry for a specific person's advance directive using a registrant's personal identifying information.
4. The registrant is responsible for ensuring that:
  - a. The advance directive is properly executed in accordance with the laws of the state of Vermont.
  - b. The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.
  - c. The information in both the *Registration Agreement* and advance directive documents is accurate and up to date.
  - d. The Registry is notified as soon as possible of any changes to the advance directive or registration information by completing and submitting an *Authorization to Change* form with the changes appended, or preferably, with an updated copy of the advance directive to the Registry.
5. Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.
6. The Registration Agreement shall remain in effect until the Registry receives reliable information that the registrant is deceased, or the registrant requests in writing that the *Registration Agreement* be terminated. When the Agreement is terminated, the Registry will remove registrant's advance directive from the Registry database, and the file will no longer be accessible to providers.
7. Only the Registry can change the terms of the *Registration Agreement*.



**Vermont Advance Directive Registry**  
**ADVANCE DIRECTIVE LOCATOR FORM**

I have prepared an advance directive, and have chosen not to submit it to the Vermont Advance Directive Registry for scanning and storage. Instead, this Locator Form identifies the location(s) of where the advance directive can be found.

Name of registrant: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

(1) Name of person holding document: \_\_\_\_\_

Location of Document: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

(2) Name of person holding document: \_\_\_\_\_

Location of Document: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

(3) Name of person holding document: \_\_\_\_\_

Location of Document: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_

Other locations where the document can be found:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attachment D**

**Registry Use Only**

Date Received:

Date Confirmed:

53101301

# Vermont Advance Directive Registry

## AUTHORIZATION TO CHANGE FORM

### Section A: Registrant information

NAME			DATE OF BIRTH
MAILING ADDRESS			
CITY	STATE	ZIP	REGISTRY REGISTRANT ID #
HOME PHONE NUMBER: (     )		ALTERNATE PHONE NUMBER: (     )	

### Section B:

#### B1. Changes requiring additional documents

- ☐ Amend      Check this box to amend the advance directive. Attach the amending statement to this form.
- ☐ Revoke partial      Check this box to cancel a part of your advance directive. Attach the revocation statement to this form.
- ☐ Suspension      Check this box to temporarily stop all or a part of your advanced directive from applying for a defined time period, or while a certain condition exists. Attach documentation detailing the parts of the advance directive to be suspended, and please describe when the,  
Suspension begins: \_\_\_\_\_  
Suspension ends: \_\_\_\_\_
- ☐ Replacement      Check this box to replace the existing advance directive.

#### B2. Changes NOT requiring additional documents

- ☐ Revoke entire      Check this box to cancel your entire advance directive.
- ☐ Delete      Check this box to delete the advance directive from the registry.
- ☐ Suspension      Check this box to temporarily stop all or a part of your advanced directive from applying for a defined time period or while a certain condition exists. Use the lines below to describe the suspension to all, or parts of the advance directive, and include when the suspension is to begin and end.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Suspension begins: \_\_\_\_\_  
Suspension ends: \_\_\_\_\_

Section C: Does your advance directive make you an organ donor? (Circle one) YES NO

### Section D: Signature

*I certify that this form accurately represents the changes I have made, and these changes are accurate. Additionally, I authorize the changes to be reflected in the Advance Directive Registry.*

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

Signature Date: \_\_\_\_\_

## Instructions

This form is to be used by the registrant of an advance directive stored in the Vermont Advance Directive Registry to notify the Registry of a change to their advance directive and to authorize the Registry to update their file with those same changes. To notify the Registry of any changes to their advance directive, a registrant can submit either a completed Authorization to Change form (with or without accompanying documents), or a signed written statement of the change and the registrant's identification number.

- 1) Section A: Complete fields with as much information as possible.
- 2) Section B1: To communicate an amendment, partial revocation, and suspension using additional documents (as attachments) to describe those changes, check the appropriate box in Section B1. The completed Authorization to Change form and attached documents will be scanned and stored as additional documents in the existing file.

To communicate the change as part of a replacement advance directive, check the 'Replacement' box in Section B1. Providing a replacement copy of the advance directive deletes the existing advance directive and all associated documents, and replaces it with the new one. NOTE: Best practices recommend changes to be communicated by replacing the existing copy with a new advance directive (replacement copy).

- 3) Section B2: To communicate the revocation or deletion of the entire advance directive, or a partial or whole suspension without attaching additional documents to describe the change, complete Section B2. Use the allotted space to describe the details of the suspension. The completed Authorization to Change form alone will be scanned and stored as an additional document to the existing file.
- 4) Section C: Circle 'YES' when your advance directive includes information which Makes you an organ donor (after the changes are made).
- 5) Section D: Print, sign and include signature date.
- 6) Attach the text of the changes, or preferably, a new complete advance directive reflecting the changes.
- 7) FAX or MAIL to: FAX (908) 654-1919  
The Vermont Advance Directive Registry (VADR)  
523 Westfield, Ave., PO Box 2789  
Westfield NJ 07091-2789
9. For additional information, visit <http://healthvermont.gov/vadr/> and login to your account to view the changes. It may take up to 10 business days for changes to be viewed online. The Registry will mail confirmation the changes have been received and processed.

# Vermont Advance Directive Registry

## PROVIDER NOTIFICATION FORM

FIRST READ INSTRUCTIONS ON REVERSE SIDE!

**IMPORTANT NOTE:** THIS INFORMATION MAY NOT HAVE BEEN PROVIDED BY THE REGISTRANT NAMED IN THE ADVANCE DIRECTIVE. THE REGISTRY IS REQUIRED BY LAW TO APPEND THIS NOTIFICATION FORM TO THE DOCUMENTS IN THIS REGISTRANT'S ADVANCE DIRECTIVE; HOWEVER, THE REGISTRY HAS UNDERTAKEN NO INDEPENDENT VERIFICATION OF THE INFORMATION CONTAINED IN THIS NOTIFICATION FORM, NOR CAN THE REGISTRY GUARENTEE THAT IT ACCURATELY REFLECTS THE WISHES OF THE REGISTRANT. IT IS RECOMENDED THAT INDEPENDENT VERIFICATION IS MADE OF THE INFORMATION CONTAINED IN THIS FORM BEFORE RELYING UPON SAME TO MAKE ANY HEALTHCARE DECISION FOR ANY PERSON.

### Section A: Identify the principal (the adult who has recorded their decisions in the advance directive)

NAME			DATE OF BIRTH
ADDRESS			
CITY	STATE	ZIP	REGISTRANT ID #
CONTACT PHONE NUMBER: ( )		ALTERNATE PHONE NUMBER: ( )	

### Section B: Identify the individual making the notification

NAME OF NOTIFIER			
NAME OF PROVIDER/ORGANIZATION			
PROVIDER/ORGANIZATION ADDRESS			
CITY	STATE	ZIP	ALTERNATE PHONE NUMBER: ( )
CONTACT PHONE NUMBER: ( )		FAX: ( )	

### Section C: Type of Change (check one box)

- ☐ **Amend** Check this box to report an amendment to the advance directive.
- ☐ **Revoke entire** Check this box to report a revocation to the entire advance directive.
- ☐ **Revoke partial** Check this box to report a revocation to a part of the advance directive.
- ☐ **Suspend** Check this box to report a temporary suspension to all or part of the advanced directive for a specific period of time, or while a certain condition exists. Describe:  
Suspension begins: \_\_\_\_\_  
Suspension ends: \_\_\_\_\_
- ☐ **Replacement** Check this box to report the existing registered advance directive is being replaced.

### Section D: Source of knowledge (check all that apply)

I have obtained the knowledge of the change to the advance directive from:

- ☐ **Principal** ☐ **Agent** ☐ **Guardian** ☐ **Other:** \_\_\_\_\_

### Section E: Provider Signature

*I hereby notify the Vermont Advance Directive Registry I have become aware of a change to the named principal's advance directive, and certify the information provided is correct to the best of my knowledge.*

Print Name: \_\_\_\_\_

Sign Name: \_\_\_\_\_

Signature Date: \_\_\_\_\_

<b>Registry Use Only</b>
Date Received:
Date Confirmed:
53101301

## Obligations of Health Care Providers, Health Care Facilities, Residential Care Facilities, Agents and Guardians

**Incapacitated patient:** Any health care provider, health care facility, or residential care facility who becomes aware of an amendment, suspension, or revocation to a registrant's advance directive while treating an incapacitated patient, shall make reasonable efforts to notify VADR of the change by completing and sending a Provider Notification form, if the patient's advance directive has been submitted to the registry.

**Patient with capacity:** Any health care provider, health care facility, residential care facility who becomes aware of an amendment, suspension, or revocation to a registrant's advance directive while treating a patient with capacity, on request shall assist the patient in notifying VADR of the amendment, suspension, or revocation, if the patient's advance directive has been submitted to the registry.

**Patient not currently receiving health or residential care:** Any health care provider, health care facility, residential care facility, not currently providing health or residential care to a registrant, which becomes aware of an amendment, suspension, or revocation to a registrant's advance directive shall ensure that VADR is notified of the amendment, suspension, or revocation by completing and sending a Provider Notification form, if the patient's advance directive has been submitted to the registry.

**Agent/Guardian:** An agent or guardian who becomes aware of an amendment, suspension, or revocation to a registrant's advance directive shall make reasonable efforts to notify VADR of the amendment, suspension, or revocation by completing and sending an Agent/Guardian Notification form, if the patient's advance directive has been submitted to the registry.

### Instructions

1. Sections A and B: Complete these sections with as much available information as possible including your relationship to the principal. The principal is the adult who has executed the advance directive.
2. Section C: Select the box identifying the original source of the information which made you aware of the amendment, suspension, or revocation.
3. Section D: Select the box corresponding to the type of change to the advance directive.
4. Section E: Print and sign your name; include signature date.
5. FAX or MAIL to: (908) 654-1919  
Vermont Advance Directive Registry (VADR)  
523 Westfield, Ave., PO Box 2789  
Westfield NJ 07091-2789
6. For additional information and forms visit <http://healthvermont.gov/vadr/> or call 1-800-584-9455.

**IMPORTANT NOTE:** This document only records a provider's notification to the Registry (as required by law) of an awareness that an advance directive has been amended, suspended, or revoked. This notification does not change the advance directive; only changes made by the principal affect their advance directive. The Registry cannot guarantee the accuracy of any information contained herein, and has not verified any of the information submitted on this form. Verification of the information contained herein with the patient or their authorized representative is recommended before relying on same to make any healthcare decisions.

# Vermont Advance Directive Registry

## AGENT GUARDIAN NOTIFICATION FORM

FIRST READ INSTRUCTIONS ON REVERSE SIDE!

**IMPORTANT NOTE:** THIS INFORMATION MAY NOT HAVE BEEN PROVIDED BY THE REGISTRANT NAMED IN THE ADVANCE DIRECTIVE. THE REGISTRY IS REQUIRED BY LAW TO APPEND THIS NOTIFICATION FORM TO THE DOCUMENTS IN THIS REGISTRANT'S ADVANCE DIRECTIVE; HOWEVER, THE REGISTRY HAS UNDERTAKEN NO INDEPENDENT VERIFICATION OF THE INFORMATION CONTAINED IN THIS NOTIFICATION FORM, NOR CAN THE REGISTRY GUARENTEE THAT IT ACCURATELY REFLECTS THE WISHES OF THE REGISTRANT. IT IS RECOMMENDED THAT INDEPENDENT VERIFICATION IS MADE OF THE INFORMATION CONTAINED IN THIS FORM BEFORE RELYING UPON SAME TO MAKE ANY HEALTH CARE DECISION FOR ANY PERSON.

### Section A: Identify the principal (the adult who has recorded their decisions in the advance directive)

NAME		DATE OF BIRTH	
ADDRESS			
CITY	STATE	ZIP	REGISTRY REGISTRANT ID #
CONTACT PHONE NUMBER ( )		ALTERNATE PHONE NUMBER ( )	

### Section B: Identify the individual making the notification

NAME OF NOTIFIER			RELATIONSHIP TO PRINCIPAL (circle one) Agent or Guardian
CONTACT ADDRESS			
CITY	STATE	ZIP	ALTERNATE PHONE NUMBER ( )
CONTACT PHONE NUMBER ( )		FAX ( )	

### Section C: Identify the source of knowledge

I have obtained the knowledge of the advance directive change from:

☐ Principal ☐ Provider ☐ Agent ☐ Guardian ☐ Other: \_\_\_\_\_

The name of this individual (if available): \_\_\_\_\_

### Section D: Type of Change (check one box)

- ☐ **Amend** Check this box to report an amendment to the advance directive.
- ☐ **Revoke entire** Check this box to report a revocation to the entire advance directive.
- ☐ **Revoke partial** Check this box to report a revocation to a part of the advance directive.
- ☐ **Suspend** Check this box to report a temporary suspension to all or part of the advanced directive for a specific period of time, or while a certain condition exists. Describe.  
Suspension begins: \_\_\_\_\_  
Suspension ends: \_\_\_\_\_
- ☐ **Replacement** Check this box to report the existing advance directive is being replaced.

### Section E: Agent or Guardian Signature

I hereby notify the Vermont Advance Directive Registry I have become aware of a change to the named principal's advance directive, and certify the information provided is correct to the best of my knowledge.

Print Name: \_\_\_\_\_  
Sign Name: \_\_\_\_\_  
Signature Date: \_\_\_\_\_

Attachment G

**Registry Use Only**

Date Received:

Date Confirmed:

53101301

## Definitions

"Agent" means an adult with capacity to whom authority to make health care decisions is delegated under an advance directive, including an alternate agent if the agent is not reasonably available.

"Guardian" means a person appointed by the probate court who has the authority to make medical decisions pursuant to 3069(b)(5) of Title 14.

"Principal" is the adult who states their decisions in an advance directive.

"Registrant" is the principal of an advance directive registered with the Vermont Advance Directive Registry.

## Obligations of Agents and Guardians

An agent or guardian who becomes aware of an amendment, suspension, or revocation of a registrant's advance directive shall make reasonable efforts to notify the Vermont Advance Directive Registry of the amendment, suspension, or revocation by completing and sending an Agent/Guardian Notification if the patient's advance directive has been submitted to the registry.

When the Registry receives the Agent/Guardian Notification, the completed form will be scanned into the registrant's file so that it is placed before previous submitted documents.

Failure to notify the Registry of an amendment, suspension, or revocation of an advance directive does not affect the validity of the amendment, suspension or revocation of the advance directive.

## Instructions

1. Sections A and B: Complete these sections with as much available information as possible, including your relationship to the principal. The principal is the adult who states his or her decisions in the advance directive.
2. Section C: Select the box identifying the original source of the information which made you aware of the change. Include the name of the individual when possible.
3. Section D: Select the box corresponding to the type of change you are reporting.
4. Section E: Print, and sign your name; include signature date.
5. FAX to: (908) 654-1919
6. Or MAIL to: The Vermont Advance Directive Registry (VADR)  
523 Westfield, Ave., PO Box 2789  
Westfield NJ 07091-2789
7. For additional information and forms visit: <http://healthvermont.gov/vadr/> or call 1-800-584-9455.

**IMPORTANT NOTE:** This document only records an agent or guardian's notification to the Registry (as required by Vermont law) of an awareness that an advance directive has changed. This notification does not change the advance directive; only changes made by the principal affect their advance directive. The Registry cannot guarantee the accuracy of any information contained herein, and has not verified any of the information submitted on this form. Verification of the information contained herein with the patient or their authorized representative is recommended before relying on same to make any healthcare decisions.